interChange Provider Important Message

Hospital interChange Updated as of 04/13/2016

*all red text is new for 04/13/2016

Ambulatory Payment Classification (APC) Scheduled for July 1, 2016

DSS will move from the current system of hospital outpatient payment methodology based on Revenue Center Codes (some paid based on fixed fees, some based on a ratio of costs to charges) to a prospective payment system based on the complexity of services performed. This change is scheduled for July 1, 2016.

Hospitals can refer to the Hospital Modernization Web page on the www.ctdssmap.com Web site for information pertaining to the APC implementation. Please send all APC related questions to Hewlett Packard Enterprise at the following e-mail address: ctxixhosppay@hpe.com.

The following document was recently added to the Hospital Modernization Web page:

- Hospital Modernization FAQs added 01/13/2016
- Hospital Based Practitioners – Outpatient Services FAQ added 03/30/2016
- Provider Manual Chapter 8 – Updated 04/07/2016 added Hospital Modernization Updates
- Addendum B has been approved by the department and added 04/08/2016
- Outpatient Fee Schedule – Updated 4/13/2016 added RCC 253. DSS will reimburse for Long Acting Reversible Contraceptive (LARC) separately from the inpatient payment only when the LARC is provided

Provider Bulletin 2016-06 – Hospital Based Practitioners – Outpatient Services

The purpose of this bulletin is to inform hospitals that they will need to create and enroll as a practitioner group(s) in the Connecticut Medical Assistance Program (CMAP) in order to bill for outpatient professional services. If the hospital has already enrolled a practitioner group as directed by Provider Bulletin 2014-68 "Hospital Based Practitioners – Inpatient Services", they are not required to enroll as a separate group. The hospital can bill inpatient and outpatient professional services under the same group.

This will ensure that hospitals will be reimbursed outside of the Outpatient Prospective Payment System (OPPS) for their outpatient professional fees for dates of service July 1, 2016 and forward. Hospitals will also need to ensure their performing providers are enrolled in CMAP under a participation type of individual provider or as Employed/Contracted by an organization and associated to their the practitioner group. Instructions for adding members to their group(s) AVRS ID can be found in Chapter 10, Section 10.18 of the Provider Manual.

Provider Bulletin 2016-02 – Billing for Partial Payment for Behavioral Health Intermediate Levels of Care

The purpose of this provider bulletin is to notify acute care and psychiatric hospitals that, effective July 1, 2016, there is a new process for billing days on which an individual does not attend the entire scheduled duration of an intermediate level of care program.

Intermediate levels of care are Partial Hospital Programs (PHP), Intensive Outpatient Programs (IOP) and Extended Day Treatment (EDT) Programs.

Hewlett Packard Enterprise

For services that qualify for partial day billing, the hospital should submit the appropriate Revenue Center Code (RCC) with one of the Healthcare Common Procedure Codes (HCPC) and modifier 52.

Updates to 835 Electronic Remittance Advice (ERA)

Claim Adjustment Reason Code (CARC) B5 is being eliminated in the February 2016 CAQH CORE updates effective for May 1, 2016 and effective 835 ERAs starting with the May 11, 2016 835 ERA.

- CARC B5 RARC N584 will be moving to CARC 272 RARC N584
- CARC B5 RARC N640 will be moving to CARC 273 RARC N362

The Adjustments between versions of the CORE Code Combinations can be found on the CAQH Web site http://www.caqh.org/sites/default/files/core/phase-iii/code-combinations/MarkedupCORE-required_CodeCombos.xlsx.

Outstanding Questions

Non-covered ICD Procedure Codes

The link below from the CMS Web site provides a list of ICD procedure codes that are non-covered procedures. The Department mirrored Medicare and has the same ICD procedure codes as non-covered. Medicaid does not have a special list posted, but providers can refer to the Medicare list of non-covered ICD procedure codes.

https://www.cms.gov/Medicare/Coding/ICD10/downloads/icd10_mce27_user_manual.pdf

Inpatient Admissions Following Outpatient or Emergency Department Services

Inpatient claims are denying with EOB codes 0671 "DRG Covered/Non-covered Days Disagree with the Statement Period" and 0672 "DRG Accommodation Days Inconsistent with the Header Date Period" for inpatient admissions following outpatient or emergency department services. Also some claims are denying with EOB code 529 "Surgical Procedure Date is prior to Admission Date."

- 04/01/2016 - The Department and HPE are still working on system updates to EOB 671 to allow these claims to be considered for payment.
- 03/01/2016 - ID and Reprocess of denied claims will be scheduled for a future cycle once system updates are completed.
- 02/11/2016 - EOB 672 was made inactive on 2/11/2016.
- 02/12/2016 – EOB code 529 was made inactive and inpatient claims that previously denied can be re-submitted for processing.

interChange Provider Important Message

Medicare HMO lab crossover claims not considering the Medicare HMO co-pay.

- 04/01/2016 - The Department has agreed that these claims should consider the co-pay amount / co-insurance amounts and is working on updates to the system to allow claims to be considered for payment. DSS is reviewing the hospital's request to reprocess claims going back to January 1, 2014.

Transgender gender clients and the eligibility process.

The hospital was asking who they can contact to provide updates to the client's eligibility in these cases and if they can bill with condition code 45 "Ambiguous Gender Category" to override claims that deny due to gender not matching.

- DSS states hospitals can contact the DSS benefits center, but any eligibility updates could require the client to provide this informational change.

- 04/01/2016 - The Department and HPE are still working on system updates to EOB 671 to allow these claims to be considered for payment.

Inpatient delivery stays denying due to lack of prior authorization when the delivery stays do not require prior authorization.

The Department of Social Service's criterion for identifying a delivery for an inpatient stay is based on the primary diagnosis on the claim. If the primary reason for the stay was a delivery, Prior Authorization (PA) is not required.

- 04/11/2016 - DSS and Hewlett Packard Enterprise have completed their review and determined that there were ICD-10 diagnosis codes that should have bypassed the PA requirement on an inpatient delivery stay. The list of codes was posted to the Web site under the Inpatient Delivery Stays (Updated 4/11/16) important message.

- 04/01/2016 – ID and Reprocess will be scheduled for a future cycle.

Inpatient Hospital REHAB claims

Inpatient DRG claims are denying for PA when the claim has a Medical DRG, but the hospital received a REHAB per-diem PA from CHN. Hewlett Packard Enterprise had reviewed these inpatient claim denials with DSS.

- 04/06/2016 - The Department has agreed that these claims should consider the rehab prior authorization and pay @ the per diem amount and is working on updates to the system to allow claims to be considered for payment.

Claims Reprocessing

Revenue Center Code (RCC) 771

Hewlett Packard Enterprise previously identified an issue where Revenue Center Code (RCC) 771 "Vaccine Administration" dates of service March 1, 2016 and forward was incorrectly denying on adult claims. The system was corrected on March 28, 2016 and any claims that were submitted for dates of services March 1, 2016 and after and before March 8, 2016 for anyone 19 years of age and older where detail lines with RCC 771 were denied can be re-submitted or adjusted for processing.

Hewlett Packard Enterprise

interChange Provider Important Message

Three (3) Day Rule: Outpatient Stay Prior to Inpatient Admission Denials

Hewlett Packard Enterprise previously identified an issue where inpatient claims were denying with EOB code 5077 “Inpatient stay denied due to a paid outpatient claim within 3 days prior to inpatient admission” and outpatient claims were denying with EOB code 5078 “Outpatient claim denied due to a paid inpatient claim within 3 days after an outpatient claim” instead of posting and paying. The system was corrected on March 24, 2016 and any claims that were submitted for dates of services March 1, 2016 and after and prior to March 24, 2016 that denied for either EOB code 5077 or 5078 can be re-submitted for processing.

Hewlett Packard Enterprise